Dr. Hey has helped patients of all ages suffering from spinal deformities and degenerative conditions.

Patient Registration Form

Personal Details

First Name ______________________

Last Name ______________________

Preferred Name ______________________ Middle ______

Birth Date ______________ Age ______________

Ethnicity
- ☐ White
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Middle Eastern/Indian
- ☐ Decline to Say

Social Security Number ______________

Guardian/Emergency Contact ______________________

Relationship ______________________

Emergency Contact Phone ______________________

Date of onset/injury? ______________________

How did you hear about Hey Clinic? ______________________

Preferred Pharmacy ______________________

Pharmacy Address ______________________

City | State | Zip ______________ ______ ______

Pharmacy Phone Number ______________

Pharmacy Fax Number ______________

Physicians

To offer you coordinated clinical care, we provide your physician(s) with assessment data and treatment recommendations resulting from the initial assessment and subsequent visits.

Primary Care Physician

Practice Name ______________________ Address ______________________

Physician Name ______________________ City|State|Zip ______________ ______ ______

Specialty ______________________ Phone ______________ Fax ______________

Referring Physician

Practice Name ______________________ Address ______________________
Physician Name ______________________ City|State|Zip ____________ ______ ______
Specialty ______________________ Phone ____________ Fax ____________

Other Physicians

Practice Name ______________________ Address ______________________
Physician Name ______________________ City|State|Zip ____________ ______ ______
Specialty ______________________ Phone ____________ Fax ____________

Practice Name ______________________ Address ______________________
Physician Name ______________________ City|State|Zip ____________ ______ ______
Specialty ______________________ Phone ____________ Fax ____________

Practice Name ______________________ Address ______________________
Physician Name ______________________ City|State|Zip ____________ ______ ______
Specialty ______________________ Phone ____________ Fax ____________

Symptoms

How bad is your pain? Please rate your pain on a scale of 0 to 10, with zero being no pain and 10 being the worst pain possible, then rate your pain quality and frequency. If you have no pain, please select "No" below and skip to the section labeled "Past Medical History."

Are you currently experiencing pain? ☐ Yes ☐ No

Please select only ONE answer from each line rating your pain intensity, quality and frequency.

How do you rate your low back pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
How would you describe your pain? ☐ n/a ☐ sharp ☐ dull ☐ aching ☐ numb ☐ shooting
How often are you experiencing this pain? ☐ n/a ☐ constant ☐ intermittent

How do you rate your upper back pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
How would you describe your pain? ☐ n/a ☐ sharp ☐ dull ☐ aching ☐ numb ☐ shooting
How often are you experiencing this pain? ☐ n/a ☐ constant ☐ intermittent

How do you rate your neck pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
How would you describe your pain? ☐ n/a ☐ sharp ☐ dull ☐ aching ☐ numb ☐ shooting
How often are you experiencing this pain? ☐ n/a ☐ constant ☐ intermittent

How do you rate your arm pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Which arm? ☐ right ☐ left ☐ both

How would you describe your pain? ☐ n/a ☐ sharp ☐ dull ☐ aching ☐ numb ☐ shooting

How far does this pain go? ☐ elbow ☐ wrist ☐ fingers

How often are you experiencing this pain? ☐ n/a ☐ constant ☐ intermittent

How do you rate your leg pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Which leg? ☐ right ☐ left ☐ both

How would you describe your pain? ☐ n/a ☐ sharp ☐ dull ☐ aching ☐ numb ☐ shooting

How far does this pain go? ☐ thigh ☐ knee ☐ ankle ☐ toes

How often are you experiencing this pain? ☐ n/a ☐ constant ☐ intermittent

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Please indicate if any of the following make your pain better:

☐ sitting ☐ walking ☐ rising from a chair ☐ cold ☐ physical activity
☐ standing ☐ lying down ☐ heat ☐ massage ☐ nothing

Please indicate if any of the following make your pain worse:

☐ sitting ☐ walking ☐ rising from a chair ☐ cold ☐ physical activity
☐ standing ☐ lying down ☐ heat ☐ massage ☐ nothing

Is your pain worse at night? ☐ Yes ☐ No

Does your pain awaken you from sleep? ☐ Yes ☐ No

Do you have problems with bladder control?
☐ no problem with bladder control
☐ difficulty emptying bladder
☐ loss of bladder control

Do you have problems with bowel control?
☐ no problem with bowel control
☐ constipation
☐ loss of bowel control

How far can you walk?
☐ cannot walk ☐ 1-3 blocks
☐ less than 1 block ☐ as far as needed

How long can you stand?
☐ cannot stand ☐ 10-15 minutes
☐ less than 5 minutes ☐ 15-30 minutes
☐ 5 minutes ☐ greater than 30 m
☐ 5-10 minutes

Is your pain relieved by bending forward? ☐ Yes ☐ No

Past Medical History

Please indicate if you currently have or had any of the following illnesses:

Condition	Past	Current	Date of Treatment (if any)
seen primary physician this year	☐	☐	
anemia	☐	☐	
angina	☐	☐	
hypertension (high blood pressure)	☐	☐	
hyperlipidemia (high cholesterol)	☐	☐	
heart murmur	☐	☐	
atrial fibrillation (A Fib)	☐	☐	
heart attack	☐	☐	
stent placement in the last year	☐	☐	
echocardiogram	☐	☐	
blood clots	☐	☐	
pulmonary embolism (PE)	☐	☐	
deep vein thrombosis (DVT)	☐	☐	
varicose veins	☐	☐	
stroke	☐	☐	
osteoarthritis	☐	☐	
rheumatoid arthritis	☐	☐	
hyperthyroidism	☐	☐	
hypothyroidism	☐	☐	
asthma	☐	☐	
chronic bronchitis	☐	☐	
previous blood transfusion	☐	☐	
dementia/Alzheimer's	☐	☐	
frequent pneumonia	☐	☐	
COPD	☐	☐	
emphysema	☐	☐	
tuberculosis	☐	☐	
sleep apnea	☐	☐	
supplemental oxygen	☐	☐	
anxiety	☐	☐	
depression	☐	☐	
substance abuse	☐	☐	
enlarged prostate	☐	☐	
hepatitis A	☐	☐	
hepatitis B	☐	☐	
hepatitis C	☐	☐	
herpes	☐	☐	
type 1 insulin dependent diabetes	☐	☐	
type 2 insulin dependent diabetes	☐	☐	
type 2 non-insulin dependent diabetes	☐	☐	
cancer	☐	☐	

Condition	Past	Current	Date of Treatment (if any)
sexual difficulty	☐	☐	
lupus	☐	☐	
fibromyalgia	☐	☐	
gout	☐	☐	
shingles (Herpes Zoster)	☐	☐	
intestinal problems	☐	☐	
anesthesia problems	☐	☐	
irritable bowel syndrome	☐	☐	
Crohn's disease	☐	☐	
ulcerative colitis	☐	☐	
GERD	☐	☐	
stomach ulcer	☐	☐	
MRSA/MSSA	☐	☐	
frequent urinary infections	☐	☐	
kidney infection	☐	☐	
kidney stones	☐	☐	
dialysis	☐	☐	
cirrhosis	☐	☐	
organ transplant	☐	☐	
liver problems	☐	☐	
motor-vehicle accident	☐	☐	
work-related injury	☐	☐	

Allergies

Please indicate any allergies you have (i.e. drugs, latex, shellfish, etc.) and your reaction to them.

Drug Allergies	What is your reaction to this allergy?

Environmental / Food Allergies	What is your reaction to this allergy?

Previous Surgeries

Please list any previous surgeries you have had.

Type of Surgery	Date of Surgery	Name of Surgeon

Family Medical History

☐ I do not know my family medical history
☐ I do not know my family medical history, I am adopted

My mother is: ☐ in good health
☐ suffers with ____________________
☐ deceased If deceased, age _____ and cause ____________________

My father is: ☐ in good health
☐ suffers with ____________________
☐ deceased If deceased, age _____ and cause ____________________

Number of living siblings _____

Number of deceased siblings _____ cause ____________________

Members of my family (parents, brothers, sisters, grandparents, aunts, uncles) suffer with the following:

☐ anesthesia problems ☐ cancer ☐ kyphosis ☐ stroke
☐ arthritis ☐ diabetes ☐ lung disease ☐ none
☐ back problems ☐ heart trouble ☐ osteoporosis
☐ blood clots ☐ hypertension ☐ scoliosis

Social History

Are you currently employed? ☐ Yes ☐ No

Employer Name? ____________________

Marital Status ☐ single ☐ married ☐ separated ☐ divorced ☐ widow ☐ widower

Do you smoke? ☐ never ☐ sometimes ☐ daily

If smoking daily, how much? ____________________

How often do you drink alcohol? ☐ never ☐ sometimes ☐ daily

If drinking daily, how much? ____________________

If drinking daily, drink of choice? ____________________

Do you commonly use street drugs? ☐ Yes ☐ No type? ____________________
(marijuana, cocaine, opiates, narcotics, methamphetamines)

Work Status

Please indicate your current work status:

- ☐ working full time
- ☐ working part time
- ☐ working part time due to back/neck problem
- ☐ seeking employment
- ☐ not working by choice (retired, homemaker, student, etc.)
- ☐ physically unable to work due to back/neck problem
- ☐ physically unable to work not due to back/neck problem
- ☐ disabled (temporary)
- ☐ disabled (permanent)
- ☐ applying for disability

What is your usual occupation? ______________________________

HIPAA Acknowledgement

I have been provided access your Notice of Privacy Practices, which contains a complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you have the right to change the terms of this notice from time to time and that I may contact you at anytime to obtain the most current copy of this notice.

Patient (or Parent/Guardian) Signature ______________________________

Date ______________________

My authorized agent(s) are as follows, which permits the following individuals (over the age of 18) to accompany my child to their appointment:

Name	Phone	Relationship

My excluded agent(s) are as follows:

Name	Relationship

Authorization to Treat a Minor Child

We must have permission from a child's parent or legal guardian before providing medical services when a child is accompanied by someone other than the parent or guardian or presents by him/her self if they are less than 18 years old.

I authorize Hey Clinic to provide medical care to my son/daughter, including, but not limited to, x-ray examinations, anesthesia, medical evaluation and/or treatment, surgery evaluation, hospital admission, and/or treatment, diagnosis, or care which is deemed advisable or necessary by and is to be rendered under, the general or special supervision of D. Hey. It is understood that this authorization is given to provide authority and power to my agent(s) to give specific consent to any and all such evaluations, treatment, and diagnostic testing which Dr. Hey, in exercise of his best judgment, may deem necessary.

If invasive diagnostic testing or surgical intervention are required, attempts will be made to contact me before such care is initiated, provided it is not to the detriment of the child's health and safety. This authorization also grants my agent(s) the power to sign for release of information to any third party payers who may be responsible or part or all the costs for the services provided. This authorization will be in effect until changed by the parent/legal guardian noted below.

Patient (or Parent/Guardian) Signature ____

Date ____________________

My authorized agent(s) are as follows:

Name	Phone	Relationship

Financial Policy

Payment for Services

We want to provide the best care possible. A portion of that care involves payment for the services we give. This information explains our policies and procedures.

Payment is expected at the time of each visit and may be made with cash, check, MasterCard, Visa, Discover, or American Express. If your visit is to be billed to insurance, please understand that the payment for these services ultimately remains your responsibility. If your insurance company does not pay after 45 days, you will be billed and responsible for the balance. Should a need arise for a bill to be mailed to you, payment is expected upon receipt. Please be aware that most insurance companies have deductibles, co-payments, and out-of-pocket amounts. Failure on our part to collect these amounts can be considered fraud. Please help us in upholding the law by paying your portion at each visit.

As a courtesy, we will verify your insurance benefits and will do our best to provide you an accurate quote for all services. The benefits we receive from your insurance is not a guarantee of payment and our quotes are estimated. It is your responsibility to keep track of your benefits and any payment that may be due. Please inform us if your insurance coverage changes. You will be asked for insurance cards and picture ID at each visit. If we are unable to confirm coverage, you will be fully responsible for your services or may be asked to reschedule to a more convenient time.

The responsibility for payment for services rendered to dependent children whose parents are divorced or separated rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office. We are only able to provide one statement to one address per patient.

Please be advised that the charges you incur from the Hey Clinic are for our services only. If you are scheduled for surgery, procedures or tests, you may receive additional charges from the other facilities involved with your treatment. You will need to call your insurance company to verify participation with other facilities involved in your treatment or if you have questions about how the claims are processed.

Claims Submission

We will submit a claim for services to your insurance company and agree to have them assign payment of benefits to Hey Clinic. Please remember your individual health insurance policy is a contract between you and your insurance company, and we are not part of that contract. Also note, some services may not be covered by your policy. By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance status or whether they make payment Should any services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed to "trick" your insurance to cover the charge. You will be responsible for the balance. Your insurance may need you to supply information from time to time. it is your responsibility to respond to the request in a timely manner. We will assist in any way reasonable to help get the claims paid including filing appeals and submitting medical records.

Referrals & Authorizations

We will assist with authorizations whenever we can and will advise you if assistance is needed. New patients and those with HMO policies will be responsible to get referrals from their PCP to ensure maximum benefits through the insurance plan.

Liability & Auto Accidents

We will provide care for post surgery patients when they have an accidental injury and bill the auto carrier for the services on your behalf. If the insurance denies payment, we can either bill the health insurance plan or you will be responsible for the balance. If the injury is considered a liability case, we will discuss this when you come in for treatment as often times attorneys are involved.

Delinquent Accounts
All balances that reach 90 days past due will be sent to a collection agency. If referred, you will be responsible for collection fees and legal fees incurred to collect the outstanding delinquent balance. Balances need to be paid in full prior to making new appointments. We currently use Transworld Systems, which can be reached at 1-800-296-2174.

Any returned checks will be assessed a $25 fee as allowed by state law. If left unsettled after 10 days, the debt will be referred to collections.

Missed Appointments
We charge $100 for any appointment not canceled with 24-hour notice and for patients who arrive more than 15 minutes past their allotted checkin time. Anyone who fails to present to their appointment more than three times, will be dismissed from the practice. This charge will be your responsibility and billed directly to you. Please help us serve you and our other patients better by keeping your scheduled appointments, which helps us to stay on-time.

Miscellaneous Charges
Following surgery, disability forms after the first will be completed for $25 each. FMLA forms will be completed for free.

Image reviews in lieu of appointment, when we did not order the study and/ or haven't seen you in a year will cost $75 for the first disc & $25 for each additional disk.

Patient (or Parent/Guardian) Signature ______________________________

Date ______________

Pain Management and Prescription Refill Procedures

Most of our patients experience some level of pain that may require medications for pain management. Please understand that the Hey Clinic is not equipped to provide ongoing prescriptions for pain management. Signing this form will acknowledge that you have received a copy of the Hey Clinic's policy on pain management and prescription renewals. Please read this entire form and, ask your clinician any questions you may have.

PAIN MANAGEMENT

1. I understand that the Hey Clinic is not equipped to treat ongoing pain management issues.

2. I understand that if I require ongoing pain management services I will be referred to a pain clinic.

3. I understand that occasionally the Hey Clinic will prescribe non-steroidal medications for pre-surgery and some non-surgical patients.

4. I understand that the Hey Clinic will prescribe medication for surgery patients up to six weeks after surgery as needed and not beyond. After that time should I need further medication management, I will be referred to a pain clinic for further evaluation.

5. I understand that if I receive narcotics from another provider while being prescribed narcotics from the Hey Clinic, the Hey Clinic will no longer prescribe narcotics for me.

PRESCRIPTION REFILLS

1. I understand that I am responsible to call the Hey Clinic (919-790-1717) at **least one week** in advance of my prescription running out.

2. I understand that I am to leave the following information on the Hey Clinic Prescription Renewal Line: name, date of birth, medication name, dosage, how often the medication is taken along with pharmacy name and phone number.

3. I understand that all non-narcotic prescriptions will be called into my pharmacy **within 24 hours** of my voice mail message request.

4. I understand that all narcotic prescriptions will be mailed to my home address of record with the Hey Clinic.

ACKNOWLEDGMENT

I hereby state that I am fully competent and have read (or had read to me) and understand these policies and my questions about pain management and prescription renewal have been answered to my satisfaction.

Patient (or Parent/Guardian) Signature ______________________________

Date ____________________

Hey Clinic for Scoliosis and Spine Surgery
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